Memorandum of Medicaid Study Group in Support of
Revisions to Proposed MQISSP Opt-out Notice

We are writing in response to DSS's draft of a notice with opt-out information related to the MQISSP program which was shared with the MAPOC Care Management Committee for its May 11th meeting. We understand that, during a work group meeting the previous day and at the CMC meeting on May 11th, consumer advocates on the Committee offered to prepare a revised notice addressing concerns that independent advocates on that committee had with the notice, and the chair of the committee allowed them until June 1st to produce such a revised notice for distribution to all committee members. We have reviewed the proposed revisions from Ellen Andrews, Karly Lee Hall and Sheldon Toubman and wish to express support for all of their proposed changes, as explained further below.

First, we think it is important to put the purpose of the notice in context. The SIM shared savings model is one which, from the outset, independent advocates in CT have generally not supported for Medicaid enrollees, especially given the particular vulnerability of low-income Medicaid enrollees, the significant success CT already has had with improving access to care through the non-risk PCMH program and other innovations, and the effectiveness of all of these initiatives in substantially controlling overall Medicaid costs—and even lowering state costs. Advocates are particularly wary of undermining that significant success through the imposition of an untested program to incentivize providers to save money on their own patients' total cost of acre, to satisfy a federal grant largely aimed at other kinds of health consumers. In addition, and for largely the same reasons, independent advocates have urged that participation in shared savings be opt-in only, so a person would have to affirmatively, knowingly make the choice of participating in this experimental program, after full disclosure of the risks of participation.

Despite these concerns, the SIM Project Management Office and DSS agreed to move forward with the proposal to put a third of all Medicaid enrollees into this experimental plan by January 1, 2017 and to deny the request for an opt-in program, such that all affected Medicaid enrollees will be included unless they affirmatively opt-OUT. Historically, very few people on Medicaid opt out of anything in response to a notice. Under these circumstances, it is extremely important that the notice that they receive explaining the shared savings program be accurate and balanced and meaningfully explain the risks of participating in this plan for purposes of calculating providers' shared savings.

The draft notice shared with the committee was extremely-one-sided, with only positive, misleading descriptions of the shared savings program included. For example, it includes the misleading claim: "The most important part of the MQISSP is that your doctor may be paid more by giving you better care and by working with you to help you get and stay well." This statement, like several others in the document, is false: while it is **hoped** that the experimental shared savings program will help to make Medicaid enrollees healthier, beyond the improvements already being seen in the Medicaid program due to other care coordination innovations, that is clearly not the design of the MQISSP model: under MQISSP, FQHCs and "advanced networks" will be paid extra as a direct percentage of money saved on their own patients' total cost of care, however saved. Potentially this could be accompanied

by "help[ing] you to get and stay well," but there is no such requirement in the plan—the money could be saved without making the person healthier and could even be at the expense of their health.

The supposed check that these providers cannot share in shared savings if they do not meet specific quality standards is very little protection against this. Those 8 or 9 measures are largely ineffective because they are very few and mostly very narrowly drawn, focusing on a few specific diseases like diabetes. For the vast majority of enrollees who do not have one of these diseases, providers will be able to keep shared savings whether or not health among their patients has been improved, which is not going to be measured. Similarly, while the Department has agreed to work with the Care Management Committee and independent advocates to develop under-service measures, DSS's Medical Director and its consultant, Mercer, Inc., have readily conceded that it will be very difficult to develop such measures which can detect the myriad kinds of under-service which might occur as a result of the incentives under shared savings. In any event, these under-service measures would be intended to detect for affirmative harm, **not** to indicate whether the consumer "stays healthier" or their doctor is "keeping you well, "as repeatedly and misleadingly claimed in the draft notice is the basis for providers receiving a bonus payment under the MQISSP program.

The draft notice also is misleading in suggesting that the only way one can get care coordination services is through being in the MQISSP shared savings program (e.g., "MQISSP coordinates care better using care coordinators in your office physician's office to help you meet your health needs," when that is what PCMHs already do, while MQISSP coordinators may actually be located elsewhere). In fact, only individuals seeing providers already participating as accredited patient-centered medical homes, which already are **required** to provide these services to all of their Medicaid patients, will be receiving the notice. The draft notice seems to be intended to encourage people to ignore their opt-out rights based on erroneous information that under MQISSP they will get something they are not already entitled to receive.

We also note that the question of what should be included and not included in written notices of shared saving programs under SIM was already thoroughly vetted by the SIM Equity and Access Council, created by the SIM Steering Committee and the Project Management Office to specifically design protections around under-service and patient selection. We caution that Medicaid enrollees are particularly vulnerable and may require more protections than developed by that Council and that the Council, while having participation by DSS's Medicaid Director, was dominated by private insurers. There is a specific protocol between DSS and the SIM Project Management Office giving all decision-making authority regarding MQISSP to DSS with oversight by the MAPOC Care Management Committee precisely because of those differences, the lack of broad involvement by Medicaid consumers and advocates on SIM bodies, and the responsibility of DSS under federal Medicaid law as the "single state Medicaid agency". However, certainly the Council's recommendations should serve as a **floor** for required information to be included in written notices to consumers.

The unanimous recommendations of the Equity and Access Council concerning communications with consumers are at pages 45-47 of its report, available at http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-07-16/eac_phase_i_draft_report_062015.pdf. Among other things, the report states:

> [Consumer communications] provide[ ]an opportunity to generate understanding among patients about how payment reform is intended to affect the way care is delivered, and about how it could unintentionally affect care delivery decisions in other, unwanted ways. Armed with this understanding, consumers may be able to advocate for themselves more effectively and discern any instances in which medically appropriate services are not ordered for them, or in which they are excluded from a provider's panel for inappropriate reasons. ….Given the combination of opportunities and challenges described above, it is important that information communicated to patients on this topic be accurate, complete, balanced, and presented in a manner and context that makes it comprehensible and actionable. (pages 46-47)

The specific recommendation about "scope" for all consumer communications regarding shared savings set forth in the Council's report is stated as follows:

> ***Recommendation #5.1: Consumer Communications: Scope.*** *Consumers should be informed about the nature of shared savings contracts, their objectives, and the financial incentives that they contain for providers and/or organizations that deliver care. This should include, but not be limited to, information about incentives to manage the total cost of care and improve quality, definitions of under-service and patient selection, and the manner in which financial incentives could lead to under- and over-service. In the context of value-based care delivery, consumers should also be informed about the nature of their role in achieving the goals of payment reform as well as their own health goals. This should include information about how to work collaboratively with one's provider, how to evaluate if one is receiving appropriate care, and what to do if one is concerned about the extent or type of care that has been ordered.* (page 47)

Based on the Council's report, it is important that the notices to consumers not only inform about the shared savings program and the right and means to readily opt-out, but also inform individuals NOT choosing to opt out about what they should look out for to protect their rights, ie, there should be "comprehensible and actionable" information about how to "advocate for themselves more effectively and discern any instances in which medically appropriate services are not ordered for them, or in which they are excluded from a provider's panel for inappropriate reasons."

The draft notice from DSS does not meet any of the requirements set forth in the Equity and Access Council's report, which, as noted, was not even focused on the special vulnerabilities of Medicaid enrollees—if anything, even more cautions are needed for them, especially if the department insists on using an opt-out procedure whereby individuals who do not respond will automatically be attributed to providers, with their shared savings calculated based on including whether money was saved on that individual's total cost of care. The draft is one-sided and will have the effect of leaving Medicaid enrollees with the dangerous impression that there is no reason at all to be concerned with the shared savings financial model, while providing no information about how to protect oneself under it and broadly overstating the benefits of participating.

Lastly, the notice is deficient in failing to identify the various ways in which opting out can readily be accomplished. This should be plainly stated so that opting out is as simple as possible.

For all of these reasons, we support the proposed revisions to the department's draft MQISSP notice to consumers as presented by the CMC's independent consumer members.